Veterans Health Administration
Chief Business Office

Inpatient Co-Payment Fact Sheet

Introduction

Veterans whose income and assets place them in a Geographic Means Test (GMT) Copay Required or Means Test (MT) Copay Required status must pay a copay and per diem charge for their inpatient care. Generally GMT Copay Required veterans are placed into enrollment Priority Group (PG) 7 and MT Copay Required veterans into PG 8. There are instances when GMT and MT Copay Required veterans can be placed into PG 6 or 4. This document will explain how fees are to be applied and provide some examples.

Policy

Veteran's inpatient copayments are described in 38 CFR §17.108, excerpted below:

(b) Copayments for inpatient hospital care.

(1) Except as provided in paragraphs (d) or (e) of this section, a veteran, as a condition of receiving inpatient hospital care provided by VA (provided either directly by VA or obtained by VA by contract), must agree to pay VA (and is obligated to pay VA) the applicable copayment, as set forth in paragraph (b)(2) or (b)(3) of this section.

(2) The copayment for inpatient hospital care shall be, during any 365-day period, a copayment equaling the sum of:

(i) $10 for every day the veteran receives inpatient hospital care, and

(ii) The lesser of:

(A) The sum of the inpatient Medicare deductible for the first 90 days of care and one-half of the inpatient Medicare deductible for each subsequent 90 days of care (or fraction thereof) after the first 90 days of such care during such 365-day period, or

(B) VA's cost of providing the care.

(3) The copayment for inpatient hospital care for veterans enrolled in priority category 7 shall be 20 percent of the amount computed under paragraph (b)(2) of this section.

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Comments	The reduced copayment can also apply to veterans in GMT Copay Required PG 6 or 4.
The Billing Clock-- Background	Every patient has a billing clock used to calculate their inpatient copayment charges. The billing clock is started by the patient's first episode of care at a Health Care Facility (HCF). The clock will remain in effect for 365 consecutive days. This is an automatic function of the VistA Integrated Billing (IB) package. The IB Users Manual V2.0 can be found in the VistA Documentation Library using the following link: http://www.va.gov/vdl/Financial_Admin.asp?appID=45 ***Note:*** Updated information on subsequent patches can be obtained through IRM.

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VistA menu options

Below are two options on the VistA IB menu which enable you to follow up on a patient's billing clock under the Automated Means Test Billing Menu (CATC).

Patient Billing Clock Inquiry (INQC).

When a patient is selected, all billing clocks for that patient are displayed. Once a specific clock is selected, the following information is displayed:

- patient name,
- reference number,
- clock status,
- primary eligibility code,
- clock begin and end dates,
- number of inpatient days, and
- 90 day inpatient amounts

Single Patient Means Test Billing Profile (PROF)

The Single Patient Means Test Billing Profile option provides a list of all Means Test charges within a specified date range for a selected patient. You will be prompted for:

- patient name, and
- date range

The output displays the:

- date the Category C billing clock began,
- bill date,
- bill type (including the treating specialty for inpatient copay charges),
- bill number,
- bill to date (for inpatient charges),
- amount of each charge, and
- total charges for the selected date range.

Note: The default at the "Start with DATE" prompt is October 1, 1990. This is the earliest date for which charges can be displayed.

Billing Scenarios

Introduction

All the scenarios utilize the current inpatient copayment authorized for year 2005 for illustration purposes. Some of the scenarios project into the future, and admissions extremely lengthy, again to illustrate the point being made.

Scenario #1— Two 90-day periods of care in one 365 day period

A veteran completed a means tested on April 1, 2004 and was determined to be MT Copay required. He did not receive medical care until he presented for an outpatient visit on May 15, 2004. On June 1, 2004 the veteran was admitted to the VAMC, and discharged on June 10, 2004. He was readmitted on August 1, 2004 and discharged August 10, 2004. He was admitted on November 1, 2004 and was not discharged until January 15, 2005.

Event	Action
Patient Means tested April 1, 2004	Data entered in system.
Patient presents for first episode of care, visit to Primary Care Clinic on May 15, 2004	365 day clock starts 
Patient first admitted 1 June 2004	90 days of care starts
Patient discharged 10 June 2004	Days 1-10 of 90 days of care (80 days remain) • Patient charged $100 per diem ($10/day x 10 days), plus • $912.00 copayment
Patient readmitted 1 August 2004	Clock continues… 
Patient discharged 10 August 2004	Days 11-20 of 90 days of care (70 days remain) • Patient charged $100 per diem ($10/day x 10 days)
Patient admitted 1 November 2004	Clock continues… 
Patient discharged January 15, 2005	Days 21-96 of care (90 days now used, into 2nd 90 day period) • Patient charged $760 per diem ($10/day) PLUS • $456 copayment
Summary: Patient used 96 days of inpatient care (not continuous) in a 365 day period and was charged: • Per diem for every inpatient day • First 90 days copayment of $912 • Second 90 days copayment of $456 (half of first copayment)	

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Billing Scenarios, Continued

Scenario #2
One admission and two 365 day clocks

The same patient who was seen in Scenario #1 continues to be seen at the HCF. He has had no episodes of care since his release from the hospital on January 15, 2005. He is admitted on July 1, 2005 and discharged July 15, 2005. He has multiple outpatient visits between his discharge and June 2006. He is admitted on June 28, 2006 and discharged July 5, 2006

Event	Action
Patient is admitted July 1, 2005.	365 day clock begins July 1, 2005. 
Patient is discharged July 15, 2005	Day 1-15 of first 90 days has been used (75 days remain) • Patient charged $150 per diem ($10/day for 15 days) • Patient charged $912 copayment
Patient is admitted June 28, 2006	Clock continues for three days. 
Patient is discharged July 5, 2006	New 365 day clock begins on  July 1, 2006 Day 16-18 of first 90 days used Day 1-5 of new year first 90 days used • Patient charged $80 per diem ($10/day for 8 days) • Patient charged $912 copayment
Summary: • Patient's previous 365 day clock closed on May 14, 2005, and began again at day #1 on July 1, 2005 because there had been no other episode of care since May 14, 2005. • Even though only 18 days of care had been used, the admission crossed over 365 days from the qualifying admission. • Patient was charged the per diem for the full admission, and • The full copayment for the new 365-day year which began July 1, 2006.	

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Billing Scenarios, Continued

Scenario #3
Two full copayments on one admission.

A GMT Copay Required veteran has not had any episode of care for over a year. Her means tests are current. She is seen in Cardiology clinic on July 1, 2004. The patient has many outpatient visits throughout the year, but has her first admission on May 15, 2005. She is not discharged until July 31, 2005.

Event	Action
Patient is seen in cardiology on July 1, 2004	365 day Clock begins July 1, 2004. 
Patient is admitted on May 15, 2005.	Clock continues 
Patient is discharged July 31, 2005	Day 1-46 of first 90 days has been used for year ending June 30, 2005 Day 1-31 of first 90 days has been used for year ending June 30, 2006 • Patient is charged $154 per diem ($2/day[$10 x 20%] x 77 days) • Patient is charged 20% of current inpatient copayment ($912 x 20% = $182.40) for year ending June 30, 2005 AND • Patient is charged 20% of current inpatient copayment ($912 x 20% = $182.40) for year ending June 30, 2006

Summary

- Patient used 77 total days of inpatient care however, the admission period crossed over the 365 day clock. (46 + 31)
- Per diem was charged at 20% of $10 for every inpatient day
- Copayment was GMT adjusted to 20% of $912 ($182.40), but was charged twice, once because there were no previous admissions for clock year ending June 30, 2005, and once for the portion of admission that follows the start of the new clock on July 1, 2006

Note: The clock is the same for Priority Category 7 veterans, but the charges are GMT adjusted.

Frequently Asked Questions

FAQs

There are many questions which arise concerning inpatient copayment charges. The following chart will attempt to provide answers to the more common questions:

Question	Answer
Does the date the means test was completed start the 365 day clock?	No
When does the billing clock "start"?	The first episode of care (inpatient OR outpatient) after the initial means test (MT). This may be the same date as the MT, or may not occur for several months.
Does the first outpatient visit start the 365 day clock?	Only if it is the first episode of care.
How does the IB software function?	Refer to the IB manual, which may be found at http://www.va.gov/vdl/Financial_Admin.asp?appID=45
Can the internal billing clock be manually adjusted if there are problems?	Yes, but only those assigned an IB Authorization security key can access this option.
A patient was charged the full means test inpatient copayment and less than 365 days later was charged it again. How can I know if that's correct?	Do a Patient Billing Clock Inquiry (INQC) and check entries for clock dates.
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